MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, September 9, 2004
10:36 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
JOHN M. BERTKO
FRANCIS J. CROSSON, M.D.
AUTRY O.V. "PETE" DeBUSK
NANCY-ANN DePARLE
DAVID F. DURENBERGER
ARNOLD MILSTEIN, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
CAROL RAPHAEL
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM:

Mandated report on the effect of implementing resource-based practice expense payments for physician services
-- Nancy Ray, Cristina Boccuti

MS. RAY: Good afternoon. Cristina and I are here this afternoon to discuss a study mandated by the MMA. It asked MedPAC to examine the effect of implementing resource-based practice expense relative value units, RVUs, on several factors, including RVUs and payment rates, access to care, physicians' willingness to care for beneficiaries. The mandate specifically asked us to look at the effect by specialty. This study is one of our 16. This one is due to the Congress December 8 of this year.

Just to briefly set a little context here, beginning in 1992 a resource-based relative value scale fee schedule for physician services replaced the reasonable charge system of payment. The intent of the resource-based relative value system is to rank services on a common scale according to the resources used for each service. The relative value scale for physician services is comprised of three components: physician work, physician practice expenses, and professional liability insurance expenses.

When the fee schedule was first implemented, the work RVUs were resource-based, that is based on time and effort of physicians, while the practice expense PLI RVUs were still based on physicians' historical charges. The 1994 statute called for developing resource-based practice expense RVUs, and the BBA mandated that they be phased in between 1999 and 2002, which they were. They were phased in, according to the statute, in a budget neutral fashion.

So the challenge here was to estimate practice expenses for each of the more than 6,000 services paid for under Medicare's physician fee schedule. CMS went final with this method in the fall of 1998 in its 1999 final physician fee schedule. The agency's approach is commonly referred to as the top-down approach.

The starting point is estimating aggregate practice expense pools by specialty, and the data source for doing that is the American Medical Association socioeconomic monitoring system survey. Expenses are allocated to each service using data derived from the clinical practice expense panels, also called on the CPEP. Fifteen expert panels were convened by CMS in the 1990s. The CPEPs were organized by specialty. Each panel had about 12 to 15 members, and the panels estimated, made judgments about the direct resources, such as nursing time and medical equipment, needed to deliver each service.

I'm going to take you through the three steps of how

resource-based practice expense RVUs are derived very quickly. Aggregate practice expenses are estimate for three direct categories: clinical labor, medical equipment and medical supplies, and three indirect categories: namely administrative labor, office expenses, and other expenses. The aggregate practice expense pool is derived by multiplying the SMS practice expense hourly data by specialty by the total physician hours treating beneficiaries.

In step 2 then involves allocating direct expenses and indirect expenses to each of the some 7,000 services in the physician fee schedule. For the direct expenses, the CPEP data is used. For indirect expenses, however, it's allocated based on a combination of physician work and the direct practice expense values. Then to derive the practice expense values by simply adding the direct and the indirect estimates per service per specialty.

Finally in step three, for services provided by multiple specialties -- because remember this was done by specialty -- CMS calculated a weighted average. So specialties that perform a given service frequently have more weight over that payment than specialties that rarely perform it.

Now of course there is always one exception to the rule. Sometimes physicians bill for services that involve little or no physician work and are performed by other staff. In response to provider concerns that payments for these services were too low, CMS developed an alternative method of calculating practice expense payments. In the alternative method, the cost of non-physician services are aggregated into what is known as the zero work pool for all specialties. Then practice expense payments are calculated for each non-physician service, as they were for other services, but with the exceptions noted in this slide. I will also add that specialty societies may request CMS to have their services removed from the zero work pool.

Now going onto the impact of implementing resource-based practice expense RVUs. The agency included in their final rule for the 1999 fee schedule a regulatory impact analysis of the effect of implementing resource-based practice expenses. They did look at the impact by specialty and they concluded that it depends on the mix of services and where the services are performed, but that specialties that furnish more office-based services are expected to experience larger increases in Medicare payments than specialties that provide fewer office-based services.

To fulfill the mandate MedPAC's analysis used 1998 and 2002 Medicare claims data to assess the effect of the transition on RVUs and payment rates per service, use of services, and changes in assignment rates. Our contractor, Urban Institute, did this analysis for MedPAC. We also used beneficiary and physician services to examine beneficiaries' access to care during the transition.

To assess the effect of the transition on RVUs and payment rates we used a price index approach. That is essentially a weighted average of current year to base year prices, holding quantity of services constant. To be clear, when we're looking

at changes in the payment rate, it does reflect the 1998 and 2002 conversion factors.

So just like the CMS impact analysis, our analysis also shows that some specialty gained and some did not. We found that the impact of implementing resource-based practice expenses increased payments across all specialties by 0.7 percent between 1998 and 2002, and during that time the payment rate overall increased by 1.9 percent.

We found that for most of the specialty groups we looked at, that the payment rates did not change by more than 2 percent. We did however find, just like CMS, that payments for certain office-based specialties like dermatology increased the most and payments decreased the most for facility-based specialties, thoracic surgery and gastroenterology.

So our results suggest that the implementation seemed to happen as the agency predicted. That the effect on a given specialty is related to the mix of services it furnishes and the kind of service.

So this table was included, or these data were included in your mailing materials, but we looked at the effect of implementing practice expense RVUs by the major BETOS categories. CMS in its final 1999 rule did not have these data stratified by the major BETOS categories. They had it done by specialty group. But again, it's consistent with the expectation, we found that payments and practice expense RVUs varied across the major BETOS categories with increases for E&M services and other procedures and decreases for tests, imaging, and major procedures.

We noted in our paper that sometimes the practice expense RVUs and payments did always change in the same direction in a given BETOS category. I specifically used the other procedure as an example. For example, the practice expense values for other procedures increased for dermatology but decreased for gastroenterology.

We're going to do additional analysis of that and have that in our report, but we are thinking that it is due to both -- there are a lot of different services included, different, varied services included in the other procedure group, and it also may partly be linked to sight of care differences.

We looked at the effect on the use of services by measuring volume two ways. By service volume, which is per capita use of services, and RVU value, which is per capita use weighted by each service's relative weight. What we found here is that the volume increased most specialties and volume increased for each of the major BETOS groups.

As we show here, in this slide we're looking at changes in volume by type of service, and then the last bar for each of the types of service is the change in the payment rate due to the implementation of resource-based practice expense RVUs. Here the changes in the volume don't seem to be related to the changes in the payment rate.

Now Cristina is going to summarize our findings on access to care.

MS. BOCCUTI: First, I'm going to start a little bit with issues about assignment rates.

Part of our congressional mandate includes examining changes in physician participation with Medicare that may relate to the transition into the RBRVS. Using the same claims data for the analyses that Nancy described, we also examined changes in the share of services paid on assignment by specialty and BETOS group. Recall that for claims paid on assignment, physicians agree to accept the Medicare fee schedule amount as the full charge for the service and may collect payments directly from Medicare.

Also, participating physicians agree to accept assignment on all allowed claims in exchange for a 5 percent higher payment on allowed charges. So here on this slide you see that the overall share of services paid on assignment were high in 1998 and increased slightly from 97 percent to 90 percent in 2002, which is our study period of interest.

By specialty, all BETOS service groups within all specialties had shares greater than 90 percent, with most greater than 95 percent. The shares stayed constant or increased for most BETOS service groups within most specialties.

So to analyze the effect of the RBRVS on beneficiary access to physician services, we examined beneficiary and physician surveys that spanned the applicable years of the transition. Most of the information that I will present about beneficiary access to physician services is really not new to you, especially considering that the relevant study period for this mandated report is from 1998 to 2002. However, in contrast to some of our work for our update analyses, the information we present for this report focuses more on specialties.

In general, beneficiaries reported good access to physicians, including specialists, between 1998 and 2002. Analysis of the Medicare current beneficiary survey shows that access measures remain relatively high and steady during this time period. Specifically, most beneficiaries reported that they were even satisfied or very satisfied with the availability of care by specialists. Similarly steady between 1998 and 2002 was beneficiary ability to see their first choice of physician.

So now we're looking at physician surveys where physicians are asked about their willingness to accept new patients. Average across all patients, overall shares of physicians accepting any new patients fell slightly, about one percentage point between 1999 and 2002. That is not just Medicare. That is all patients, when we're looking at multiple surveys. Although a small decline was detected, results from a MedPAC-sponsored physician survey indicate that among open practices the share of physicians accepting new Medicare fee-for-service patients remained high, above 90 percent.

Using a larger survey, the National Ambulatory Medical Care Survey we call NAMCS, which included both open and closed practices, shows a small decline by 2002 in acceptance of new patients across all insurance types except to their charity care patients. Specifically, the share of physicians accepting new privately insured patients fell from 92 percent to 86 percent, and the share accepting new Medicare patients fell a little less, from 90 percent to 87 percent.

So when looking at trends in physician acceptance of new patients during our study period, both surveys suggest that proceduralists and surgeons were more likely to accept new Medicare patients than non-proceduralists, namely primary care physicians. In the NAMCS surveys, surgeons were most likely to accept new patients across all years and all patients types. This survey found that the share of surgeons who accept new Medicare patients slightly increased to 96 percent in 2002. The NAMCS survey also found that the share of Medicare physicians who accept new patients dropped at the same rate for both Medicare and privately-insured patients, which was just a few percentage points.

Nancy will continue.

MS. RAY: Thank you. So we want to summarize our findings of our data analysis and present these draft conclusions for your consideration, that changes in the practice expense RVUs and payments, what we found is consistent with CMS's impact analysis. Our analysis shows that the transition had the expected effect, and that payments for most specialty groups did not change by more than 2 percent.

We also found that changes in volume do not seem to be related to changes in practice expense RVUs or payment changes. Beneficiaries are not facing systematic problems accessing care, and assignment rates remained high and mostly unchanged during the transition.

Just to very briefly touch upon some future MedPAC issues that we can take on after we finish all of our mandated studies. With respect to practice expense, the first is the need for updating data sources, the SMS and the CPEP, to have current and up-to-date data to derive practice expenses, and then exploring alternative methods to calculate practice expenses. Many policymakers have focused in on the allocation for non-physician services.

With that, we are finished.

MR. HACKBARTH: Questions or comments?

DR. REISCHAUER: I realize that these questions were, in a sense, mandated by the law, but the notion that the shift in this index would have a big effect on physician participation is ludicrous, given all the other things that go on. I would hope that in our report, which I think you did a first-class job. I don't say that just because the Urban Institute was involved in this, but we say there are lots of things that affect volume, and some of them are big and important, and lots of things that affect participation. Some people might think this does too, but clearly whatever effect it might have had has been swamped by all the other things that are going on.

DR. NELSON: I hope that we mention a requirement for all physicians to submit cost report data, as is done with institutional providers. I hope we mention it only to deplore that notion, because for solo and small group practices whose office manager may or may not be a spouse, that could be the straw that broke the camel's back.

MS. DePARLE: I agree but I just want to underscore the last issue you raised about the data. The SMS, as I recall, the house

of delegates of the AMA voted not to do that anymore. At least the AMA is not doing it now, and the data is now four years old that we are using. So even though this report is not supposed to necessarily deal with that issue, I think we should note in the report that the Secretary needs to find another source of data. When this all started I think the agency tried to do a survey of doctors and that didn't work. But we've got to find some better way. I don't think the cost report is the right way to do it, but there's got to be some better way to get data. Even what they're using now is inadequate for some of the different procedures, as I understand it.

DR. NELSON: I think it's really important for MedPAC to talk to the AMA and find out what and under what circumstances they would be able to continue to provide the necessary data.

MR. HACKBARTH: I think we are very near the end of this particular study and close to ready to send our report. What we will do is hold it open until the next meeting, in keeping with our general rule of allowing commissioners time to think about things and have ample chance to get in their comments. But I think that we are in pretty good shape on this one and would hope to get it to the Hill before the deadline. So I'm not sure exactly how Mark will want to handle it at the next meeting. There will not be an extensive discussion of this unless something surprising happens in the intervening weeks, and we'll maybe just have a very cursory follow-up report and a draft out.